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ABSTRACT

This paper presents the case for furthering the profession of counseling psychology by affiliating with a department of medicine and not working only within traditional graduate programs. Counselor training programs have explicit expectations for faculty to execute a research program that makes a unique contribution to the field. Medical schools expect psychology faculty to conduct a program that attracts external funding which in turn serves as a sign of external validation. This clear mission, along with a supportive infrastructure, makes it easy to do research deemed necessary for scholarship and service. Health care delivery to persons with chronic diseases and disabilities constitutes the greatest challenge facing health care today, and the effective treatment of these problems is a priority of policymakers and federal funding agencies. The paper questions whether mainstream counseling psychology, as represented by the majority of research published, is responsive to this national priority. Counseling psychologists are ideally prepared to demonstrate the worth of psychological explanations of behavior and associated interventions in promoting the health and well-being of persons with chronic health problems. It suggests development of a research program that would have theoretical and practical applications and have an impact on health care policy and delivery. (JDM)

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Both Sides Now: From Academic Counseling Psychology To Health Care

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Some of you may know that I was affiliated with the counseling psychology program at Virginia Commonwealth University from 1987 to 1993; I left that position to work with the Department of Physical Medicine and Rehabilitation at the University of Alabama at Birmingham. This was a dramatic move for my family and me. We loved living in Virginia and we still have many dear friends there. But on the very day I received my official letter of promotion to Associate with tenure I packed up the pickup and drove south to Birmingham to take my position as an untenured Assistant Professor in the UAB medical school.

As a graduate of the counseling psychology program at the University of Missouri in Columbia, I was primed to champion counseling psychology at every turn. Yet after several years in a counseling training program it became obvious that my particular interests, goals, and activities were valued more by colleagues in other psychology disciplines than by those in a more tradition Division 17

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pathway. Second, as my research program developed, I became aware that my professional interests would require greater support in infrastructure and in available resources than typically found in a counseling training program in order for my work to have a greater impact on theory and service delivery.

I carefully considered the differences between life one lives in academic counseling psychology and in an academic medical center. I was wary of moving into a medical school setting, because I knew well the different expectations counseling psychology programs and medical school departments have for their faculty. In part, counseling psychology training programs have an explicit expectation for their faculty to execute a recognizable research program that makes a unique and appreciable impact. This is essential for favorable external reviews for tenure. Faculty members are also expected to contribute to the life and organization of the program and in training doctoral students.

Cynically and implicitly -- and I heard this a hundred times in my former life at VCU -- you also must publish in *JCP*. If it's not in *JCP*, then how can it be considered unique to counseling psychology? How can it advance counseling psychology? How can you be identified with counseling psychology, and how can your research promote the national reputation of the program? Perhaps, to some degree, appearance in *JCP* and in other associated outlets

provides a certain external validation of the worth and relevance of an individual research program.

In contrast, the medical school environment expects psychology research faculty to conduct a program of study that attracts external funds, preferably from federal agencies (preferable still from an NIH agency). Funding from an NIH agency is recognizable to colleagues from other departments who work on standing internal review committees. It is seen as a sign of external validation of the merit and worth of a research program. Faculty members are also expected to provide services to colleagues and clients if practice is a part of the position. Cynically and implicitly, the real issue is money in today's medical center. Make it or else. This reinforcement schedule holds true for all faculty members, from junior to senior. Tenure means little in this respect; Full Professors are not spared. There is no guarantee that your department will survive the year -- let alone your position – if the money isn't there at the end of the fiscal year. These are the dilemmas facing medical schools in our country.

I learned at VCU that infrastructure and resources make the difference in developing competitive grant proposals. Please note that I can only speak for my experience during the seven years I was there, and I have many friends on faculty there who can attest to the changes that have occurred since that time. At VCU, I had to "walk my own grant" through the Dean's office and the IRB after I had

made my own copies, worked up my budget sheet by myself, and begged colleagues in nearby hospitals to let me interview patients for my project.

At UAB, my senior colleague and good friend Scott Richards showed me the research service he was instrumental in setting up. This staff brings grant announcements, types up dictated manuscripts, does literature searches, works up budgets and financial statements, makes copies of the proposal, walks proposals through the IRB and the Dean's office, and mails grant submissions on their recognizance.

At VCU, I submitted a dozen grant proposals to external sources. One small grant to a private agency was funded. At UAB, I joined a team that has had continuous funding since 1978. I was awarded part of a five-year center grant from the National Institute of Disability Rehabilitation and Research before I moved into my new office in June of 1993. I work with colleagues who have their own grants, who offer advice, counsel, and guidance. We have access to funding agencies and policymakers affiliated with these agencies. I am part of a larger whole that works and collaborates on research endeavors.

While the press to "make money" is onerous in many respects, the supportive infrastructure and clear sense of mission has many dividends. I am able to do the research I deem necessary for scholarship and service. In return I contribute to departmental center grants that nurture the long-term goals of the

department. Successful grantsmanship is incumbent upon supportive infrastructure and a shared mission between faculty members and department. But there are two other major factors that provide valuable insight into the nature of my work, and the nature of my relationship with my university and my profession.

Note that I study the adjustment and concerns of persons with chronic disease and disability. Specifically, for some time I have studied persons with spinal cord injury and I am looking at ways to help family caregivers who assist these persons. Contrast this population with the samples frequently appearing in *JCP* articles. Buboltz and colleagues (1999; *Journal of Counseling Psychology*) reported that over 55% of research samples in articles appearing in *JCP* from 1973 to 1998 were college undergraduates; an additional 6.2% were graduate students. Less than 1% were adults with medical problems and adults with some "vocational/rehabilitation" concern.

On any given day in our country, health care services to persons with chronic disease and disability, and to the acute episodes of basic care associated with these conditions, ranges from 40% to 70% of all health care expenditures. The tax-supported programs that have provided the safety net of care for these persons – Medicare and Medicaid – have dwindling reserves. Medicare is projected to be insolvent within eight years without radical overhauls from elected officials reluctant to address these problems. Managed care entities know well the costs

associated with these conditions and most circumscribe care to these persons, if they provide any coverage at all beyond the care associated with initial treatment and rehabilitation, which in turn forces these persons onto tax-supported health care programs.

Thus, health care delivery to persons with chronic disease and disability constitutes the greatest single challenge facing American health care today, and the effective prevention and treatment of these problems and their associated complications is an outstanding stated priority of policymakers, federal funding agencies, and private funding agencies. Prevention of these conditions, the prevention of secondary complications following the condition, and the promotion of personal health and well being are behavioral issues, open to behavioral interventions, and subject to the theoretical explanations of behavior and behavior change.

The enterprise of theoretical development and refinement with samples of college students has its place in psychological science, but it is not a stated national priority among policymakers and the external funding agencies that recognize and attempt to meet these national priorities. Furthermore, in the extreme this enterprise is not responsive to the stated national needs of policymakers and their respective agencies that work to address these needs. Counseling psychology has the research and therapeutic expertise to contribute mightily to meeting these

priorities, and it has a rich heritage of being responsive to national needs. But I have worried for many years that mainstream counseling psychology – as represented by the bulk of the research appearing in *JCP* and other outlets traditionally associated with the discipline -- is not responsive to the national priorities articulated by federal funding agencies and policymakers. Evidence for this in part is reflected in the low level of federally supported research appearing in mainstream counseling psychology journals in the recent past (Elliott & Shewchuk, 1999). I have a subsequent concern that the lack of grant supported research has resulted in a pervasive disregard and pessimism about grant-funded research and its importance in the policymaking process. Consequently, future generations of counseling psychologists will have little or no exposure to the granting writing process, and have little appreciation for the value of policy-relevant research.

Counseling psychologists are ideally prepared to demonstrate the worth of psychological explanations of behavior and associated interventions in promoting the health and well being of persons with chronic health problems, with appreciable and measurable reductions in health care costs. In fact, several of my colleagues in rehabilitation psychology have backgrounds in counseling. John Corrigan, president-elect of Division 22 and director of the Model Systems Traumatic Brain Injury project at Ohio State is a graduate of the Ohio State counseling psychology program. His opponent in that presidential election, Dan

Rohe, was one of the founding fathers of the diplomate in rehabilitation psychology now a part of the American Board of Professional Psychology; Dan is a graduate of the Minnesota counseling psychology program. I suppose you could conclude that three-quarters of the MOMM cartel is alive and well in Division 22! In a way, I followed their lead to pursue my professional interests in an environment other than the academic program. It was time for me to have the courage of my own convictions.

And I suppose that is the next major factor that must be considered in this transition. I wanted to develop a research program that would have theoretical and practical applications and in the process, have an impact on health care policy and service delivery. I had to either be true to my interests, and find an environment that would support them, or radically change my research interests altogether. I believed that models of social problem solving would help us understand adjustment of persons with chronic conditions, and that problem-solving interventions would prove efficacious in helping persons and families living with these conditions. We have a nice track record supporting the former position; we have completed one three-year intervention study funded by the CDC and we now have two five-year intervention projects now funded by NIDRR and the CDC. I am also convinced that traditional fee-for-service models of care are anachronistic in the ongoing treatment of persons with chronic health conditions. Our first

intervention study featured a home-based, face-to-face intervention for family caregivers; the two current intervention projects utilize visual telecommunication devices to train caregivers in the home. I also collaborate in another study with a colleague in Nursing to determine the effectiveness of a telephone-based problem solving intervention program for stroke caregivers, funded by NIH. These intervention are theory-based, practical, and fit well within capitated care programs that can be accommodated by many health care delivery systems, potentially with low-cost service providers.

I chose to affiliate with a medical school because I want to participate in finding solutions to the problems facing American health care. I want my research to have a direct impact on the delivery of services to people who may be denied, or have restricted access, to care of any sort. I believe these personal and professional goals are best met, for me, in the medical school setting.

Closing Remarks

Dr. Altmaier has observed that counseling psychologists who work in health care can maintain their counseling identity by (a) accepting a diversity of identities in counseling psychology, (b) remaining current in counseling psychology, and (c) providing feedback to their specialty areas. I concur, but add that this line of communication should be reciprocal: Mainstream counseling psychology has much to learn from those of us who work in these specialty areas.

Counseling psychology must reframe its emphasis on counseling process and outcome research in such a way that it responds to national health care priorities. In order for academic counseling psychology to attract and maintain support from federal and state agencies, it must recognize and respond to these priorities. Counseling psychologists must demonstrate how their expertise can be used to meet these national priorities. Applied academic programs in state-supported institutions will face increasing expectations from state agencies to meet recognized needs of states and localities. We have the interest and the skills; we need the redirection, the support, the infrastructure, and the sense of mission.

This will require in part active support for those colleagues who want to develop competitive grant proposals that can attract external funding. Theory-driven research with practical applications with at-risk populations is highly valued. Policy-relevant research will also involve the study of outcome variables that are clearly associated with health and public expenditures. These kinds of outcomes should be included; this will require greater expertise and familiarity with these kinds of variables. Pilot data can be obtained from collaborating sites that can then attract small research or service grants from private agencies. These projects, in turn, can be used to develop competitive NIH-type proposals. This activity will also require active collaboration with colleagues in other disciplines

and cooperating sites; it will also necessitate greater advocacy and explicit support from senior colleagues, administrators, and Division 17 leadership.

This will also require greater recognition of the need to have counseling psychologists on standing review panels at the various NIH agencies. In my review of these panels – and they are posted on NIH web sites -- there are many psychologists who are known for their work in clinical, health, rehabilitation, social, developmental, and gerontological psychology. But I have yet to find a counseling psychologist that I recognize on any standing review panel. For far too long counseling psychologists have not pursued work in policy-related areas: I am delighted that a counseling psychologist – Jim Werth – has served as a recent APA Congressional fellow. NIH also offers other programs that can prepare colleagues for the granting process. For example, my post-doctoral colleague, Patricia Rivera, submitted a proposal to the National Institute of Aging to participate in their Summer Institute of Aging. Her proposal addressed the Longitudinal Effects of Aging on Caregivers of Persons with Spinal Cord Injury. Her proposal was one of 45 out of 200 funded, and she participated in a week of seminars learning how to critique and craft competitive research proposals, and learning about the various avenues of support at NIH.

I hope our leaders in counseling psychology will recognize the larger role we can play in forging health care and public policy in the coming years. The

dynamic changes in American health care may make access to health care one of the most divisive issues in our society in the coming years. Counseling psychology research and practice has great potential in meeting the needs of our health care system at all levels of policy and service delivery.